ORM FERTILITY

Outgoing Medical Records

Authorization to Release Medical Records from ORM Fertility to Self/Provider
****Hard copy releases can be faxed to 503.208.2741 or upload to your ORM Fertility Patient Portal****

Patient Name ______________________ DOB ____ /____ /____ Phone ______________
Partner Name *(if applicable)*______________________ DOB ____ /____ /____ Phone ______________
Address ____
City ______________________ State ____________ Zip ____________

I AUTHORIZE ORM FERTILITY TO SEND MY RECORDS TO:

Provider Name ______________________ Clinic Name ______________________
Address ____
City ______________________ State ____________ Zip ____________
Phone ______________________ Fax ______________________

Send Via:
- ◯ Mail to Home Address
- ◯ Email: ______________________
- ◯ Upload to Patient Portal
- ◯ Fax: ______________________

Types of Records to be Released:

- ◯ Physician Consult Notes
- ◯ Operative Reports
- ◯ Hysterosalpinogram (HSG) Report
- ◯ All Records
- ◯ Treatment Records
- ◯ Laboratory Reports
- ◯ Semen Analysis/Antisperm Antibody Testing
- ◯ Other: ____________
- ◯ Ultrasound Reports
- ◯ Embryology Reports

**Embryology requests require consent from patient and partner (*if applicable)*

Purpose of Request:

- ◯ Shipping embryos/eggs from ORM to another facility
- ◯ Billing/Insurance
- ◯ Treatment/Consultation
- ◯ Patient Request
- ◯ Other: ____________

Certain protected or sensitive information cannot be released without specific authorization as required by State/Federal law. I understand that this information will be disclosed if I/my partner place my/our initials in the applicable space next to the type of information.

______ ______ HIV/AIDS Information
Patient *Partner*

______ ______ Drug/Alcohol Diagnosis/Treatment *(*includes only the required psychological evaluation/consult held by the Licensed Psychologists of ORM*)*
Patient *Partner*

______ ______ Genetic Testing Information
Patient *Partner*

______ ______ Mental Health Information *(*includes only the required psychological evaluation/consult held by the Licensed Psychologists of ORM*)*
Patient *Partner*

Duration and Right to Revoke Authorization: This authorization can be revoked at any time by submitting a notice in writing. Such revocation would be effective upon receipt. Unless revoked, this authorization is valid for both the patient and the patient's partner/spouse.
Redisclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal HIPPA regulations.
I understand the ORM/RML will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.

______________________________ ______________
Patient Signature *Date*

______________________________ ______________
Partner Signature (if appliable) *Date*